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## ORIGINAL DEPARTMENT.

### Communications.

#### Operation for Knock-Knees by the Subcutaneous Division of the Tendon of the Biceps Femoris, with Cases.

By A. G. WALTER, M. D.,  
Of Pittsburgh, Pa.

The deformity known by the name of "*knock-knee*," though not of frequent occurrence, and generally not of a nature to deprive the person thus affected of active locomotion, is nevertheless a serious and unsightly infirmity. Mostly originating during infancy and childhood, in consequence of weakness of the muscles of the lower limbs, orthopaedical means have been resorted to with the view of restoring the knee-joint to its original position. The process of restoration, however, has usually, after much time and labor spent by the surgeon, and discomfort endured by the patient, been very slow, imperfect, and mostly unsuccessful. Though the principle upon which mechanical appliances are to act in redressing the deformed joints is a plain one, the proper adjusting and retaining the same upon the limbs of the patient for locomotive purposes is not only irksome and painful, but mostly fruitless. Considering the anatomico-pathological relation of the deformed joint, we find that the *head of the tibia* is not only thrown *inwards* from its natural line with the femur, but at the same time *somewhat twisted around its axis*, the outer portion of the glenoidal surface of the tibia being received by the posterior part of the condylus externus. On the inner side of the joint there is *diastasis* between the in-

ner condyle of the femur and the head of the tibia, the inner ridge of the latter being somewhat in advance of the inner condyle of the femur, while the outer ridge of the tibia is drawn behind and in close proximity with the posterior surface of the external condyle of the femur; the head of the tibia, too, being brought in close apposition with the condyle. This unnatural deviation and twisting being brought about by the yielding of the fibrous and muscular apparatus of the inside of the knee-joint under the weight of the body, in consequence of the impaired innervation of the muscles of the limbs, cannot last without structural contraction taking place on the opposite side of the joint. Thus we find that the tendon of the biceps femoris, being inserted into the upper part of the fibula, is in a state of structural tension during the attempt of forcing the limb into its natural position, while the knee-joint is kept extended. But in the flexed position, the configuration of the joint appears natural, and the action of the corresponding bones normal, no contraction of the muscles inserted into the crus being perceptible. The moment, however, the joint is extended and the head of the tibia prevented from twisting around its axis, the tendon of the flexor biceps becomes tense, and resists the attempt made to bring the femur and crus into their natural line.

No mechanical contrivance of our suggestion, or that of any other surgeon, being able of overcoming this tension of the biceps, and of preventing at the same time the semi-rotation of the head of the tibia, *subcutaneous section* of the implicated tendon *alone* seemed to promise relief. Though sanguine of success by tenotomy, still permanent relief without a long

continuance of the supporting apparatus to the joint, appeared doubtful in cases of old standing, as it was reasonable to suppose that absorption of the articulating surface of the outer half of the joint, and new bony deposit upon its inner half, would have taken place. The joint thus altered, and its articulating surfaces changed from the transverse to the oblique, being but illy able to support itself, would easily be displaced without steadiness being given to it for a long time, till by nature's absorbent and modelling power the corresponding surfaces had again returned to their original shape.

Experience, however, has not verified these conjectures. The articulating surfaces being but slightly, if any, altered, and structural contraction overcome once by tenotomy, the joint becomes restored to its natural position, and remains normal, a supporting apparatus only being needed for a comparatively short time.

Not being aware of any attempt to relieve this deformity by division of the flexor biceps femoris, none having been made public, I may lay claim to originality in offering the result of the following cases as confirmatory to the success of the practice, which recommends itself by being painless, easy of execution, and of speedy effect, not depriving the patient of the use of his limbs but for a few weeks.

Orthopædia having thus far failed in affording relief in the hands of most surgeons, resection of a V shaped piece from the head of the tibia has been resorted to with success by Dr. Mayer, of Würzburg, in 1851, (the case having been reported in the *London Lancet*.) Original, and yet successful as the latter operation has been in the hands of the Doctor, its hazard, however, and the prolonged confinement to which the patient had to be subjected in consequence of it, cannot fail to prevent its introduction, the necessity being entirely superseded by the successful results of *tenotomy*, in conjunction with gradual extension, as shown by the report of the following cases:

*Walter Pope*, 4 years of age, of Pittsburgh, was born well formed and healthy. When one year old dentition, accompanied by diarrhoea,

reduced his strength, in consequence of which lateral deviation of both knee joints gradually and steadily took place. The upper part of his body grew naturally, the lower limbs remaining placid and diminutive.

He is tolerably active, still falls frequently, both knee-joints touching each other, while the feet are widely separated, the patient resting on the inside of the foot, with the toes pointing outwards. The deformity is very great; the deviation of the crus from the natural line of the femur amounts to some seven inches. There is a semi-rotation outward of the head of the tibia, occasioned by the contraction of the tendo bicipit. femoris. On flexing the knee-joint the deformity disappears, but returns on extending it. The natural line of the tibia, also, has diverged from a concave to a convex one, the curvature being outward and somewhat forward. On October 6th, 1858, assisted by Dr. Henderson, the tendon of the biceps femoris was subcutaneously divided above its insertion into the fibula, the patient being under the influence of sulph. ether, and a tin splint, well padded, and hollow to fit the leg, laid upon the outside of the whole limb, confined by a roller from below upwards. No fever followed. The extension of the joint being daily increased, the patient, a few weeks after, began to stand upon his limbs. A few weeks later walking was commenced, with the knees still supported in the extended position. An orthopædical apparatus was then attached to his shoes, with a joint at the knee, resting upon the outside of the limb, by which the latter were kept in their restored positions. The boy rapidly gained strength, and was able, in six months, to walk without any support, which had been left off by his parents, the deformity not having re-appeared at the present date.

*Peter McCoy*, a lad of 16 years of age, of Alleghany city, born healthy. Contracted measles, followed by whooping cough, when three years of age, which reduced him greatly, and prevented locomotion for some time. Some months later he began to walk, when lateral deviation of the knee-joints inwards took place, and gradually increased. The knees touched

each other, the feet were widely separated, and the toes everted. The shaft of the tibia, also, bent inwards and forwards under the weight of the body. Various were the appliances tried by his physicians without avail. Tenotomy of the biceps femoris, above the fibula, was made on November 12th, 1858. A hollow tin splint was applied to the limb, and the gradual extension of the joint commenced a few days after. The deformity yielded gradually to the extending force, and was relieved at the expiration of three weeks. The boy began to stand upon his feet and walk with stiff knees for a few weeks, when the orthopaedical apparatus was attached to his limbs, allowing him full freedom of motion. This was worn for a year, and then left off, the deformity not re-appearing. The muscles of the crus, before flaccid, have regained their natural fullness; even the shaft of the tibia having perceptibly returned to its natural line.



Peter McCoy, 16 years of age, of Alleghany city.

As before the operation, Nov'r 12, 1858.



One year after the operation.

Henry Galbraith, 6 years old, of Pittsburgh; when born, was feeble, thriving but slowly; dentition was slow, and accompanied with protracted diarrhoea. He did not begin to walk until two years old, and then his knees already began to bend inwards. The upper part of his body increased in bulk and strength, while the lower part remained feeble. Locomotion, however, became pretty

active, but increased the deformity, which was already very great, the feet turning as in confirmed valgus. The tendo bicipit. femoris was subcutaneously divided May 6th, 1859, under the influence of ether. Extension began a few days after, and was kept up for three weeks. The boy was then allowed to walk, the limb being supported by an apparatus. This was continued over a year, was then left off, no inclination of the deformity to return being perceptible. Since, he has become stronger, and bids fair to pass his childhood in health and vigor.

Mary Ann Eicher, of Pittsburgh, aged 5 years, of decidedly scrofulous constitution, plump and fleshy; was two years old before she could walk, her body being too heavy for the strength of her limbs. When she had passed her third year, scarlatina disabled her from walking for four months. Last fall her knees began to give way without any percepti-

ble cause, gradually bending inwards. Though never active on her feet, she could walk tolerably well, but would frequently fall, the knees striking each other. The deformity in this case, too, is very great; the line of the femur diverges at the knee-joint to almost a right angle, the tibia is curved inwards, the inner side of the soles of the feet touching the ground, with toes everted. On June 12th,

1860, in presence of Drs. McClelland, of Westmoreland county, and J. Greenawall, the tendo bicipit. femoris was divided, and gradual extension was commenced a few days after; the limbs at present being straight, and the patient already having the use of them, though supported by the outer splint. She walks about with ease, and will be able to dispense with the apparatus some months hence.

July 14, 1860.

### Scrofulous Disease of the Spine;—Communicating Abscesses—Death—Autopsy.

By C. C. SHEPARD, M. D.

Resident Physician of Philadelphia Hospital.

Wm. L., twenty-five years of age, born in Scotland, shoemaker by occupation, entered the Philadelphia Hospital, April 17, 1860. While in health he weighed about one hundred and fifty pounds. Of late he had lost flesh considerably. His complexion was pale and scrofulous, eyes very clear and blue, hair light.

On his admission, he complained of no pain, except in the lumbar region on the right side, extending through the bowels. Nausea and continuous efforts to vomit were present.

From his own account, and that given by his friends, it appeared that some weeks previous to his admission he had suffered from intermittent fever, for which he had been treated. He had also complained of pain in the abdomen, above the right kidney, and in the neighborhood of the liver. No hereditary predisposition in the family. Four years ago he had had a cough; but none for the last two years, except when taking slight colds during winter. During the last fourteen months he had been a hard drinker.

Supporting treatment was employed, with morphia and blisters. He gradually sank and died May 14, 1860.

*Autopsy* 36 hours after death, general emaciation; brain not examined.

On opening the chest, the pleura of both sides was found thickened; both lungs bound down by adhesions, those of the right side being of recent formation, as shown by masses of whitish grey lymph upon the right pleura. A lympho-purulent, greenish looking mass

was discovered between the 4th and 6th ribs. On further examination an abscess was found, the walls of which extended from the cartilages of the sternum to the vertebral column, from the 4th to 9th rib, and a communication existed with another abscess around the head of the 6th rib, communicating with the periosteum of the left side of the spinal column. The vertebral column in this neighborhood was found diseased four or five inches. The head of the sixth rib and the corresponding vertebra, with its transverse processes, were softened. This latter abscess communicated with the base of the lung on that side, and the pus found its way into one of the bronchial tubes. The bronchial glands were enlarged. The right lung was softened and highly oedematous. The left lung was congested, particularly posteriorly, and the upper lobe highly oedematous. Both lungs seemed to be the seat, more or less, of small metastatic abscesses.

The liver was enlarged, and somewhat fatty. The spleen enlarged to double its natural size, and its structure soft and pulpy. Left kidney enlarged and somewhat vascular; right kidney normal in size and structure, with the exception of incipient fatty degeneration.

### Tubercular Deposits in the Walls of the Heart.

By C. C. SHEPARD, M. D.

Resident Physician of Philadelphia Hospital.

A colored boy, aged fourteen years, entered the hospital with a greatly enlarged and painful elbow joint, which was discharging profusely from several sinuses. With the object of relieving his sufferings and getting rid of the drain on his system by the continued suppuration, and at the same time to save the limb, the operation of resection of the elbow joint was performed by Dr. D. H. Agnew, in the month of February, 1859. The entire joint was removed, and the parts healed rapidly, allowing some slight flexion and extension.

A temporary relief was obtained, and the patient improved in appearance, but the disease soon reappeared at the resected parts, and suffering and emaciation again ensued.

In August, 1859, the arm was amputated



through the upper third, by Dr. R. J. Levis. The stump healed at once, and the patient was again restored to apparent health.

On the 7th of June last he re-entered the hospital, with a large scrofulous tumor on the left side of the neck, involving the submaxillary gland and adjacent cervical lymphatics. His appearance was otherwise healthy, and he complained of no pain.

He died suddenly, three days after admission.

An autopsy was made thirty hours after death. The tumors were large, and contained softened tubercular deposit, and the mass pressed deeply on the subjacent nerves and vessels. Miliary tubercles were diffused throughout the upper portions of the left lung.

On the pericardium were several black masses, which appeared to be melanotic. The heart was double its natural size, and the walls very much thickened; *tuberculous deposits existed abundantly in the muscular structure of the ventricles.*

On examination of the brain, liver, kidneys and other organs, no further tubercular disposition was discovered.

## Medical Societies.

### PHILADELPHIA COUNTY MEDICAL SOCIETY.

(Reported by Wm. B. Atkinson, M. D.)

WEDNESDAY EVENING, MARCH 28.

Dr. COATES presiding.

*Subject for Discussion: DIPHTHERIA—continued.*

(Continued from page 317.)

Dr. NEBINGER said, that, upon a previous evening, he had made some observations upon the so-called diphtheria, and at the conclusion of his remarks had asked "if the experience of the members would warrant them in regarding scarlet fever and the so-called diphtheria as the same disease, differing only in variety, as, for example, scarlatina simplex differs from scarlatina maligna." The object of the question, as then announced, was for the purpose of giving broader scope to the discussion. The inquiry has not met with the attention, nor called forth the facts, he was confident the members are possessed of, and which he had hoped it would. For one, he was happy in having an opportunity

to declare that his conviction, based upon observation and reason, is, that diphtheria is an accumulation and development of morbid phenomena, produced by the *materies morbi* of scarlatina; that it is scarlet fever without the rash; and here he would remark, that there is not a wider departure in the morbid phenomena of the so-called diphtheria from those of scarlatina maligna, than there is in the phenomena of scarlatina simplex from those of scarlatina maligna; and if diphtheria cannot be regarded as a variety of scarlet fever, because of the absence of the eruption, it is equally as reasonable and philosophical not to regard scarlatina simplex as a variety of scarlatina, because the angina is absent—the disease of the fauces in scarlatina being at least as important, and as attractive as a phenomenon of the disease, as is the efflorescence of the skin. In diphtheria we have all the phenomena that we have in scarlatina maligna, with the exception of the rash; whilst in scarlatina simplex all the striking and important phenomena of scarlatina are absent, with the exception of the eruption. Indeed, regarding scarlatina maligna as the type—the full expression of all the phenomena of fully developed scarlatina—then is it true that diphtheria is vastly more like the type than is scarlatina simplex, and being more like the type, and springing up under the circumstances which it does, examples of which he narrated on a previous evening, it deserves to be recognized as a form of scarlet fever.

In this view, he was happy to say he was not alone. When, on a previous evening, he declared his conviction that diphtheria was a diseased condition of system produced by the scarlet fever poison, and that all it wanted to constitute it undoubted scarlatina was the eruption, he was not aware that he was sustained by so much authority as, by a reference to a few works on disease, he finds is the case. How largely he is sustained, he was not able to say, as he has, in his consultation with authorities, been from his daily engagements unable to go beyond his office library. To these authorities he begged to call the attention of the members. Dr. Wood, in his article on scarlatina, remarks, "It is certain that cases of fever with sore throat sometimes occur during the prevalence of scarlet fever, having all the symptoms and running the exact course of that disease, whether in its milder or malignant forms, with the single exception that the eruption is wanting. It is even stated by Willan, that such cases are capable of imparting scarlet fever." (Wood's Practice, p. 402, vol. 1.)

At this time, scarlet fever is prevailing in Philadelphia, and co-existing with it is this so-called diphtheria, a disease which, whether in its milder or malignant forms, presents symptoms and condi-

tions so close in their resemblance to scarlet fever, that if the slightest amount of eruption was present, it would unhesitatingly be pronounced scarlatina; and it is doubtlessly to this form of scarlet fever—the scarlet fever *faucium* of some writers—that Dr. Wood refers when he says, “Cases of fever with sore throat occur . . . having all the symptoms of scarlet fever, and running the exact course of that disease, with the exception that the eruption is wanting.” If then it is, in its symptoms, so nearly allied to scarlatina, that it requires the presence of the eruption only to make its identity positive and undoubted, and as it is possible that cases of scarlet fever of the malignant form do occur without the rash, the mere absence of the eruption in diphtheria is not sufficient to cause us to regard this as another disease than scarlatina, particularly when it has, as its sequelæ, the same secondary affections as succeed scarlet fever. But are the symptoms of diphtheria and scarlet fever analogous? Let us compare them: Scarlatina maligna is introduced sometimes with a rigor, at other times with only slight chilliness. Diphtheria, of a severe form, is also introduced by a decided rigor, or with slight chilliness. In scarlet fever, you have decided febrile action following the rigor; so do you have in diphtheria. In scarlatina maligna, you have the feeling of great prostration, pain in the back, limbs, swelling of the tonsils, and patches of lymph or pseudo-membrane upon them, erythema of the fauces, and enlarged and painful cervical lymphatic glands. In diphtheria, you have the same feeling of prostration, pain in the back and limbs, tumefied tonsils, dotted with patches of lymph or membrane, erythema of the fauces, and swelled and painful cervical lymphatics.

Thus far the symptoms of the two diseases are alike, springing up in the same order and running in parallel lines with each other. But in scarlatina maligna you generally have an efflorescence of the skin. I say generally, not universally, and in this only is it that the resemblance does not hold between these two forms of disease. But as we have high authority for declaring that cases of fever with sore throat sometimes occur, and run the exact course of scarlet fever, with the single exception that the eruption is wanting, and that scarlet fever with the eruption has been contracted by persons coming in contact with those, Dr. N. said he felt himself justified in concluding that the so-called diphtheria is a disease produced by the scarlatina poison; and hence that it is scarlet fever without the rash—“scarlatina faucium.”

Again Dr. Wood remarks: “The epidemic influence differs greatly in its effects in different instances, . . . occasionally causing a particular direction of the irritation—sometimes, for example, to the bowels, sometimes to the air passages, and some-

times with especial violence to the fauces.” (Ib. p. 404, vol. 1.)

At this time, scarlet fever is prevailing in Philadelphia, and in this instance, owing to some peculiar susceptibility or impressibility of persons, “the peculiar direction of the irritation” is “with especial violence to the fauces and air passages,” and is giving rise, in some cases, to that form of scarlatina called by some scarlatina faucium, because the fauces are seriously involved, and the skin is without any efflorescence upon it, thus constituting that form of scarlet fever referred to by Dr. Wood, when he says “it is certain that cases of scarlet fever with sore throat sometimes occur, having all the symptoms, and running the exact course of the disease in its malignant form, with the single exception that the eruption is wanting.” As, then, we have shown by authority—which indeed it were almost superfluous to adduce, as each member present is authority to himself, having witnessed the fact—that “scarlet fever with sore throat, running the exact course of that disease in its malignant form, without the rash,” does sometimes exist, we feel, therefore that the absence of the rash in the so-called diphtheria is not of itself sufficient to justify us in rejecting it as a form of scarlatina, and that we must have other and positive evidence to warrant us in deducing such conclusion; has such evidence been presented, or can such be adduced? He thought not, while the evidence is not difficult of production to prove the identity of scarlatina and diphtheria.

To some of the evidence establishing this proposition, Dr. N. said he would now invite the attention of the society. The same authority we have been quoting, Dr. Wood, in his article upon diphtheria, uses this language: “From its (diphtheria’s) resemblance to the malignant sore throat of Fothergill, Huxham, and others, with which it is by some writers maintained to be identical, and, from the simultaneous occurrence of both the affections with epidemic scarlatina and the close analogy of their local symptoms with the throat affection of that disease, the inference is not without plausibility that they may all be produced by the same cause.” (Ib. p. 499, vol. 1.) Dr. Wood further observes, that “the malignant sore throat described by Fothergill, Huxham, and Cullen,” under the name of *cranche maligna*, is now universally admitted to be a modification of scarlatina. (Ib. p. 502, vol. 1.) Thus, then, we have Dr. Wood first declaring “that diphtheria is by some writers maintained to be identical with the malignant sore throat of Fothergill, Huxham, and others;” next asserting that “the malignant sore throat described by Fothergill, Huxham, and Cullen, is now universally admitted to be a modification of scarlet fever;” therefore diphtheria being this malignant sore throat, hence

it is a modification of scarlet fever. Dr. N. thought the day was not far distant when Dr. Wood would be found recording of the Fothergills, Huxhams, and Cullens of our day, who are endeavoring to make out of the so-called diphtheria a disease which has not its origin in the scarlet fever poison, and therefore not a modification of scarlatina, that they have fallen into error, as "it is now universally admitted to be a modification of scarlet fever." If Fothergill, Huxham, and Cullen, with their fine powers of observation, great acumen, and exalted reflective powers, were not able to discover, in their *cynanche maligna*, modified scarlet fever as "it is now universally admitted to be;" and if at not a very long time ago medical observers were not able to draw the line of demarcation between scarlet fever and measles, but classified both diseases under the head of the latter, it is not, while we hold these facts in view, very wonderful, if wonderful at all, at the present time, that some of us, with acumen, powers of observation and reflection not superior to those possessed by Fothergill, Huxham, and Cullen, should not be any more able than they were to recognize, in the so-called diphtheria, modified scarlatina. Indeed, in this very room this evening, we have had a specimen of morbid anatomy presented by a member, and we have seen, while he who presented it regarded it as a diphtheritic specimen, another regarded it as a scarlet fever product; and both of these are gentlemen of great experience, acknowledged ability and authority. When such disagree, who shall decide? But (said Dr. N.) I must hurry on with my authorities. Dr. Willan (*Cutaneous Diseases*, p. 277, 281) remarks, "It is truly singular that the slightest of all eruptive fevers, and the most fatal disease known in this country, should rank together and spring from the same origin. Experience, however, (he continues) decides that simple scarlet fever, the scarlatina anginosa, the scarlatina (or angina) maligna, and the scarlet ulcerating sore throat, without the efflorescence on the skin, are merely varieties of the one disease; that all of them proceed from the same source of contagion is evident, because, under the same roof in large families, some individuals have the disease in one form, some in another, about the same period."

Just such cases as those referred to by Dr. Willan of scarlatina without efflorescence on the skin, are those that I described on a previous evening, and these are the cases which are being called diphtheria, but which were recognized by Willan as the scarlet ulcerating sore throat without efflorescence on the skin, having their origin in the scarlet fever poison, and hence is a variety of scarlatina.

Dr. Billing (*First Principles of Medicine*) observes, "It is by no means uncommon for those

who have had the disease (scarlet fever) to suffer from sore throat, scarlatina faucium, when they are in attendance upon one laboring under scarlatina."

Dr. Johnstone has related, in his description of epidemic scarlatina which prevailed in Worcester in 1778, that some individuals at the first seizure were, more or less, severely attacked with the scarlet eruption, with swelling, redness and ulcers of the throat; yet others, in the same family, infected from them and by them, had ulcerated sore throat without any efflorescence or eruption on the skin."

In a paper entitled "Cursory Remarks on the Appearance of the Angina Scarlatina in 1793, by Dr. Lettsom," several cases are given of this form of scarlatina: "In one case, the disease assumed the character of scarlatina maligna, but without the efflorescence."

A. Tweedie, from whose article upon scarlatina, contributed to the *Cyclopædia of Practical Medicine*, these authorities have been taken, endorses them by saying, "These statements concur exactly with our own experience. . . We had lately an opportunity of observing in one family the simultaneous appearance of the various forms of the disease."

In a lengthy and able report of the diseases of Missouri and Iowa by Dr. Thos. Rayburn, published in the eighth volume of the *Transactions of the American Medical Association*, he gives a history of an angina accompanied with erythematous redness of the fauces, tumidity of the tonsils and *exudative action*. In remarking upon it, he says: "Accompanying the scarlet fever which occurred in St. Louis county, there was an erythematous angina; that an unusual tendency was observed in subjects of all ages towards erythematous angina during the scarlet fever epidemic. The angina did not confine its attacks to subjects who had been previously unaffected by scarlet fever, nor yet to such as were exposed in the vicinity of cases of that disease. Its symptoms were erythematous redness of the fauces, with but slight tumidity of the tonsils, the follicles of the region were tumid, and in a few instances presented exudative action. Pain in deglutition, soreness of the muscles of the neck, some tumidity of the lymphatics beneath the angles of the jaw, with a grayish pasty coating over the tongue." In every twelve deaths by scarlet fever, there was one by this angina. If Dr. Rayburn had been called upon to describe the so-called diphtheria which is now prevailing in this city, his description would be precisely his description of the erythematous angina of Missouri and Iowa, which doubtlessly was the scarlet fever sore throat, without rash of Dr. Wood and the scarlatina faucium of other writers.

Thus, then, (said Dr. N.) I have presented authorities and facts which clearly establish that scarlet fever anginosa without the rash does frequently

present itself, and that, too, in some instances in a malignant and deadly form. It being established, then, that scarlet fever can exist and there not be any eruption, it will not do to declare that diphtheria is not a form of scarlet fever, because the rash is wanting. There now remains to be shown (said Dr. N.) the close resemblance—nay, the identity between scarlatina and diphtheria—to prove the common origin of both diseases. Can this be done? We shall see. "The simultaneous occurrence," almost universally, of scarlatina and diphtheria is significant, and strongly suggestive, of the common origin of the two affections. If this is not the case, then it is truly wonderful—the intimate companionship, not to say relationship, which exists between the blood poisons which produce these diseases, an intimacy so close that they cannot be separated. It would appear, indeed, that they noiselessly move abroad, locked arm, as it were, each selecting his victim upon whom to breathe its peculiar foul and deadly venom.

It has been admitted, nay, it will not be denied, that the so-called Diphtheria is followed by the same sequelæ as follow scarlatina. We have as the sequelæ of diphtheria, rheumatic pains, perulent discharge from the ears, dropsy, albuminuria, and anemia. What more have we as the sequelæ of scarlet fever? Thus then, from our own observation, as well as from those who have written upon diphtheria, we know that not only in its introduction and development that it resembles, yea, is identical with scarlatina, save only that the eruption is not present; but we also know that in its sequelæ it is identical with the sequelæ of scarlet fever. Then, with these facts before us, and then recollecting that undoubted authorities and observers have declared that scarlet fever in its malignant form sometimes exists without any efflorescence on the skin, how can we come to any other conclusion than that diphtheria is a variety of scarlatina—scarlatina faucium. Then, too, how this conclusion is strengthened, when we reflect upon the treatment which has been almost universally declared as the most successful in the management of the malady. The accumulating evidence at this day in regard to what is the best medication in scarlet fever, points to chlorine in some form as the internal, and nitrate of silver as the local remedies. And is not this medication almost universally admitted to be by far the best treatment for diphtheria? I am compelled, said Dr. N., to regard diphtheria as an accumulation and development of morbid phenomena, produced by the materies morbi of scarlatina—first, because of the almost universal co-existence, or simultaneous occurrence of diphtheria and scarlet fever; second, the close resemblance of the two forms of disease, in their introduction and development; third, their sequela; and fourth, the simi-

larity of the treatment of the two diseases. To me, said Dr. N., this conclusion is rational and irresistible. He could not come to any other. And so, concluding, he held that diphtheria is the "scarlatina faucium" of Willing, Tweedie, Billing, and Johnstone; the "scarlet fever, without the eruption," of Wood; "the cynanche maligna" of Fothergill, Huxham, and Cullen; the "scarlatina maligna without efflorescence on the skin" of Lettsome, and the "erythematous angina" of Rayburn.

[NOTE.—Since the discussion, I have treated a case of the so-called diphtheria, which by its phenomena demonstrated to me that this disease, as I in the discussion endeavored to prove, is only a form of scarlatina, and not a distinct disease. As a brief report of the case referred to will not be without interest, especially in connection with the discussion, I here give it:

Mary W., aged 10, was seized, on Sunday, April 1st, 1860, with a chill, followed by fever, sore throat, difficulty of deglutition, pain in the head, back and limbs. Her mother, regarding the little girl's indisposition not serious, treated her with domestic remedies, until Tuesday, April 3d, when, becoming alarmed at her daughter's condition, I was sent for. When I visited her, she had much fever, her pulse was small and quick, her skin dry, her countenance distressed and anxious; she complained of severe headache, soreness of the neck, and great difficulty and pain in swallowing. Upon examining her mouth and throat I found the tonsils much tumefied, so much so as to have forced the uvula out of its normal position. The tonsils were nearly covered with thick patches of lymph, or diphtheritic membranous deposits; the soft palate and arch of the mouth was of a dingy scarlet hue, the tongue moist and coated. The little girl's general and local symptoms being grave, I stated to the mother the imminent peril her child's life was in, and in response to her inquiry of the nature of her daughter's illness, remarked that she had scarlet fever sore throat, or scarlet fever without the rash. On Thursday, the third day after she came into my care, I saw indications, for the first time, of amendment. On the following day, Friday, her symptoms of amendment were more decided. This day her mother called my attention to her skin, saying, that since last night a rash had been coming on her skin. I examined her, and found that her mother's statement was correct, and that the rash was the scarlatina eruption. On the following day, Saturday, when I visited her, upon examining the surface of her body, I discovered that the eruption had so completely disappeared that it was scarcely observable.

The point of great interest in this case is, that although the little girl was taken ill on Sunday, and her constitutional symptoms and her angina were grave, it was not until Friday, the second day after



her improvement commenced, and the fifth day after she was attacked, that the rash made its appearance; and notwithstanding it was universally diffused over her body and limbs, and was of a decided scarlet color, it continued but twenty-four hours. This case had about it all the marks or symptoms of the so-called diphtheria, and had it been seen by Bretonneau himself, I feel confident he would, from Sunday up to Friday, have pronounced it an unmistakable, well-marked case of diphtheria; and so it was his and other's diphtheria; and the rash, the scarlet rash, just manifested itself on Friday and continued twenty-four hours, to demonstrate that diphtheria is not a distinct disease from scarlatina, but a form of that malady—that it is "scarlatina faucium."]

Dr. CONDIE entirely agreed with the gentleman that, so far as relates to the general pathological character of the diseases, a very close relationship exists between membranous angina, croup, scarlatina, and he would add, also, erysipelas. The very close similarity in many of their features, between membranous angina and certain epidemics of erysipelas that have prevailed widely throughout a large portion of our western country, and denominated, from the early and prominent implication of the tongue and fauces, "black tongue," has been pointed out by more than one of those by whom we have been furnished with descriptions of such epidemics.

In all of the diseases referred to, including perhaps croup in its epidemic form, the throat affection is secondary, evidently, to some general morbid condition of the system. A poisoned state, probably, of the blood. The exudation upon the mucous membrane of the fauces is somewhat different, it is true, in each of these diseases, in respect, at least, to its color, consistency and adhesiveness, yet not so much so, but what in cases of membranous angina, scarlatina, and faucial erysipelas we may have suddenly developed all the symptoms of croup. While, in cases of epidemic croup, besides the presence of the same adynamic type of fever which is seen in membranous angina, the effusion upon the mucous membrane of the throat does not commence, as in the sporadic form of the disease, to form in the larynx, but, as in membranous angina, upon the tonsils, soft palate, and pharynx, and from thence extends into the larynx.

But while Dr. Condie admitted a general relationship to exist between the pathological conditions of the system in the diseases referred to, he could not agree with Dr. Nebinger, that membranous angina, croup, and scarlatina, were identical in all respects. That such is the case with respect to membranous angina and croup was maintained, he was aware,

by Bretonneau, Barthéz and Rilliet, and Guersent, and long before their time, by Bard and Johnstone, but the correctness of the observations upon which their decision is based may be, very properly called in question.

As respects scarlatina, cases do, certainly, not unfrequently occur, especially of the more severe forms of the anginose variety, which it is very difficult to distinguish from well marked severe cases of membranous angina. The very fact that the latter disease is liable to prevail at the same time with the former is strong evidence of the close relationship of the two, but cannot be adduced in support of their absolute identity.

In proof of such identity, Dr. Nebinger would seem to place great weight upon the fact that, many of the sequelæ observed after an attack of scarlatina are also observed often to follow in the train of membranous angina, such as severe pains of the limbs, dropsical effusion and albuminous urine, etc. From this circumstance, however, no evidence can be derived in favor of the position assumed. It indicates merely that in both diseases the entire system is involved. It was remarked on a certain occasion by Professor Jackson, that the presence of albuminous urine could not be received as pathognomonic of any particular malady, inasmuch as it has been detected in almost every severe disease; it is certainly of very common occurrence in almost every affection in which the entire system becomes involved, especially in blood diseases like membranous angina and scarlatina. In these, the kidneys being affected in common with all the other organs, it is but reasonable to suppose that their functions would be to a greater or less extent disturbed, even if their entire disorganization should not occur.

Between membranous angina, croup, scarlatina, and erysipelas, it is certain that a very broad and decided diagnosis may be drawn.

Thus, in cases of ordinary sporadic croup, the inflammation commences, and in the first instance is confined to the larynx, its extension, when this takes place, being into the trachea. While, on the other hand, the asthenic inflammation of the throat in angina membranacea, commences in the tonsils, pharynx, and soft palate, and extends usually into the posterior nares and œsophagus. In idiopathic croup, there is neither fetor of the breath, discharge from the nostrils, nor swelling of the lymphatic glands of the neck. The occurrence, also, of diphtheritic deposits on any portion of the surface of the body that has become from any cause denuded of its cuticle is in cases of croup of very rare occurrence. In croup, again, when the termination is favorable, the period of convalescence is short, the patient rapidly regaining his normal condition of health,

while 'the reverse is the case in respect to membranous angina.

From scarlatina in its more open and regular forms, membranous angina is to be distinguished by the absence of the characteristic eruption of the surface, and of the peculiar punctated appearance of the tongue so commonly observed in the early period of the former disease, by the slower formation of the membraniform coating of the faucial mucous membrane in scarlatina, and its entire absence in nearly all of the milder cases, and by the absence in membranous angina of the extensive desquamation of the cuticle, often in large patches, with which scarlatina is always succeeded.

From erysipelas of the faucial mucous membrane the diagnosis of membranous angina is attended with greater difficulty than is the case in respect to either croup or scarlatina. Particularly difficult is the diagnosis in cases of faucial erysipelas, where this is neither preceded nor accompanied by any disease of the skin. In erysipelas of the throat, however, there is far greater tumefaction of the affected parts, apparently of an oedematous character, and of the tongue, also, than usually occurs in membranous angina. The exudation which takes place upon the mucous membrane of the fauces in the latter disease is softer, less membraniform, and often of a puriform character, while, from an early period in the attack, the tongue is very commonly of a dark mahogany or even black color, dry, and deeply chapped.

Dr. Condie concluded by observing that, while he considered it to be of importance that the general relationship of the several diseases referred to with membranous angina in their leading pathological character, should be kept steadily in view, he nevertheless believed that, to view them all as identical affections would be replete with the most mischievous consequences.

Dr. J. C. MORRIS thought that the difficulty of breathing in the case narrated by Dr. Darrach, might be explained by reflex action. The surfaces which exhibit such intense inflammation in the specimen are precisely those to which the glosso-pharyngeal nerve is distributed; or rather to speak more correctly, those from which it conveys impressions to the central nerve-ganglia. If a crumb of bread or other irritating foreign matter becomes lodged in the pocket between the epiglottis, violent coughing spells occur attended often with shrill whooping inspiratory efforts, as no doubt we have frequently seen. This is due to the action of the inferior laryngeal nerve and the spinal accessory, which are distributed to the muscles of the larynx and neck mainly concerned in respiration. Two instances have been brought under my notice, in which the function of the pneumogastric has been

interfered with in the human subject. The first was that of a child, who had suffered under scarlatina anginosa, but was doing well and able to sit up. An abscess formed in the neck and suddenly broke into the sheath enclosing the pneumogastric, causing the almost instant death of the child. The second instance was that of an infant four months old, who was seized with an inflammation of the right tonsil and lymphatic glands in its vicinity, which ran on to suppuration in a few days. The symptoms closely resembled those following the section of the pneumogastric on one side; great difficulty of swallowing from the passage of fluids into the larynx, constant accumulation of mucus in the fauces, with slowness and irregularity of the respiratory movements in which the accessory muscles were called into play. The abscess discharged internally on the fifth day, immediate relief being thereby obtained. I think that in this case, pressure upon the pneumogastric from the neighboring tumefaction prevented the due performance of its functions; and do not doubt that death would have ensued if the pressure had not been relieved.

Adjourned.

## EDITORIAL DEPARTMENT.

### Periscope.

**Snake Bites.**—Dr. W. D. Johnson, of Herando, Mississippi, reports, in the *New Orleans Medical and Surgical Journal*, (July,) his experience with tobacco and alcohol, as antidotes in the bites of poisonous reptiles and insects. He has used tobacco both externally and internally, combined, however, with free alcoholic stimulation. The tobacco produced nausea and vomiting in every case in which it was resorted to. Dr. Johnson regards either as efficacious when administered in time, and both together more prompt than either separately. He considers the patient as safe when nauseated or intoxicated, and proposes the internal administration of alcoholic stimulants, and the local application of tobacco, either as cataplasm, decoction, or infusion, as the best treatment. The local application of the tobacco greatly relieves the pain consequent on the swelling, and tends to arrest the swelling itself.

**Death from Chloroform.**—In the July number of the *New Orleans Medical and Surgical Journal*, Dr. Humphrey Peake, of Yazoo city, Mississippi, relates a case of death

from chloroform, occurring in his practice. The patient was a man much debilitated from previous disease, irregular life and intemperance, and suffering from disease of the leg, for which amputation was resorted to. He was brought very readily under the influence of the anæsthetic. While the cutaneous section (circular operation) was being made, the patient's breathing and pulse suddenly stopped. Artificial respiration was resorted to, but without success.

*Substances introduced with the Air into the Lungs.*—M. G. Pouchet, in a communication made to the Académie des Sciences, (see *Gaz. Heb.*), states that he has found in the respiratory organs of man the same atmospheric corpuscles which he has found in animals. In two persons who had died in one of the Parisian hospitals—a man and a woman—whose lungs he injected, Pouchet found a notable quantity of wheat dust, particles of silica and fragments of glass, small particles of wood of a fine red tint, debris of clothing, and finally a larva of a microscopical spider, yet living.

M. Pouchet has met with debris of the same nature in the expectoration.

## Reviews and Book Notices.

*On Obscure Diseases of the Brain and Disorders of the Mind.*—Their incipient symptoms, Pathology, Diagnosis, Treatment, and Prophylaxis. By FORBES WINSLOW, M. D., D. C. L., OXON. etc., etc.—Blanchard & Lea, 1860.

The author of this volume has long been known as one of the most ardent cultivators of that difficult and interesting branch of medicine, *mental diseases*. His labors as the editor of the "Psychological Journal," his writings as an author, his lectures as a teacher, are replete with instructive observations and facts. Forbes Winslow stands acknowledgedly at the head of English psychologists. There is one peculiarity in which his writings favorably differ from those of others. What he says is to the point; his sentences are perspicuous, his style fluent. Opening a page in the work before us, at random, we find but one sentence occupying more than five lines. All the rest are not more than two or three lines in length. This style of writing shows that the author is dealing with facts, and that he knows how to state them.

Nowhere is such a style more desirable than in treatises on insanity. How often have we been driven nearly to despair, when obliged to peruse a work, in which every sentence was overshadowed by a metaphysical cloud, and where facts were so fenced in with commas, semicolons and parentheses, that we had to leap boldly and climb tediously to get at them.

We have said this much about the style of the book, to assure our readers that in treating "obscure diseases of the brain and mind," the author does so in by no means an obscure manner. To read this volume is not only an easy and instructive, but a pleasurable task. Every point upon which the author dwells is illustrated by cases and clinical observations.

The first chapter is devoted to a consideration of the importance of paying early attention to cerebral disorders. All affections of the brain have an incipient stage. This, unfortunately, is often neglected, the symptoms overlooked, until the disease is manifest in its full violence, and the patient frequently beyond the reach of medical treatment.

The morbid phenomena of intelligence are next taken up. It is hardly necessary to say that Dr. Winslow belongs to the somatic school of psychologists. Yet, with laudable modesty, he throws aside this "complex question," simply affirming, "as a general postulate, that all structural lesions of the encephalon, its investing membranes and blood vessels, are associated with some derangement, modification, or altered action of the *physical, motorial or sensorial* functions of the great cerebral ganglion, *πρωτον Αισθητηριον*, the sensorium commune." These derangements are then discussed seriatim. The mind may be in a state of morbid

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| 1. Exaltation. | 3. Aberration. |
| 2. Depression. | 4. Impairment. |

These conditions of unhealthy intelligence, says the author, exhibit in their origin, progress, and termination, a variety of shades and degrees of disturbance, and disease, commensurate with the nature, extent and position of the cerebral lesion.

The premonitory symptoms of insanity are considered in a short chapter. The great analogy between certain forms of insanity and dreaming is dwelled upon. Here the author advances nothing new. Indeed we can hardly believe that the mental phenomena of insanity, dreaming, etc., will ever be better described than has been done years ago by Abercrombie. The next chapter is devoted to the confessions

of patients after recovering from insanity; or the condition of the mind when in a state of aberration. Curious, certainly, are some of the descriptions which recovered patients give of their condition during attacks of insanity. Some interesting cases of this kind are quoted from the American Journal of Insanity. The state of mind on recovering from insanity is then dwelt upon by the author, and, like the former chapter, illustrated by observations.

Though curious and interesting, in a practical point of view, the chapters which we have so far enumerated, are not very important. The very nature of insanity, as far as its mental manifestations are concerned, is that the patient always confounds the *objective* with the *subjective*, or, rather, that he loses, more or less, the power of perceiving and reasoning *objectively*. Little reliance can hence be placed upon the patients' recital of his condition during, and while recovering from, an attack of insanity.

With the next chapter, (VI.) Dr. Winslow enters into the consideration of questions of deep practical interest—anomalous and masked affections of the mind. Insanity in children and young persons is first discussed. The following two cases occurred under the author's own observation. A young gentleman, whilst studying for university honors, had an attack of insanity. He was sitting up late at night, busily occupied in reading, when he was suddenly seized with an impulse to destroy everything within his reach. He first broke the lamp on the table, then a pier-glass; he subsequently tore up and destroyed a number of books, and did great injury to several articles of value in the room. He left home about three o'clock in the morning, and came back at eight, covered with filth, *apparently in full possession of his senses!* He refused to give any explanation of his conduct, or to say where he had been. When pressed upon the subject, he became irritable, sullen and morose. This gentleman continued mentally well for twelve years, when insanity again developed itself, and he has remained from that period in a deranged state of mind. A patient, now insane, manifested, at the age of ten, decided symptoms of mental aberration, and to such an extent, that, occasionally, for days it was deemed necessary to confine mechanically the hands, so mischievous were the child's tendencies. At the age of fifteen, he, appearing like other boys, was sent to a public school, and it was not until he was *thirty* that his insanity again manifested itself, and then it was

considered necessary to place him under restraint. In juxtaposition with these cases, the author quotes Esquirol, Pinel, Briere du Boismont, to show that the causes of insanity do not act abruptly, except when the patients are strongly predisposed. "Almost all the insane exhibit, before their disease, some alterations in their functions, alterations, which commenced many years previously, and even in infancy. The greater part had had convulsions, cephalalgia, colics or cramps, constipation and menstrual irregularities." (Esquirol.)

In our own country, the age between twenty and thirty, according to Dr. Winslow, shows the strongest disposition to insanity, while in England the age between thirty and forty shows the maximum; "and this is fairly ascribed to the earlier age at which young men enter the world and engage in business and politics. One of these beardless men of business said to his physician, 'I am convinced this kind of life which I lead will drive me mad or kill me; but I must go on.'"—"In four American asylums, which contained 2790 patients, 33.73 per cent. were between twenty and thirty, and 24.41 per cent. between thirty and forty years of age. That the kind of education which the youth in the United States receive has a powerful influence on the development of insanity is proven by Evans and Worthington, in their reports of the Pennsylvania asylums. Dr. Wigan gives, in his unpublished writings, an account of crimes committed by young people without any object. The age of the youthful malefactors was between sixteen and seventeen for girls, and between seventeen and eighteen for boys. There was this in common, that there had not previously existed the slightest animosity towards the persons against whom they perpetrated outrages. According to Wigan, the great number of these young people had epistaxis, which among the females appeared with the regularity of menstruation. The crimes were generally committed after the temporary cessation of this habitual flow."

We have thus quoted at length because the subject is one of immense importance to the American people. Insanity, suicide, and juvenile crime have for years been on the increase, and it becomes one of the most important social questions of the day, how to counteract these evils. To do this, it is necessary to strike at the very root of the evil, and nip it in the bud. "*Mens sana in corpore sano*" must be made the very basis of the educational system of our country before we can expect a



better state of things. Children are now condemned to a sedentary life in crowded school-rooms, when they ought to run wild in gardens and meadows; their brain is made to dwell upon things intellectual and spiritual, when they have hardly acquired nerve-power enough for the purposes of energetic and proper muscular motion; their fancy and imagination is excited before they have had time fairly to accustom their eyes and ears to the realities of the outer world;—is it a wonder that our miserable system of the education of the young, destroying the physical health while it is yet in its early growth and development, leads to idiocy, insanity, suicide and crime? Add to these already powerful causes, the fast life of our American people, and we need no longer be astonished at the remarkable increase of insanity, and the early period of life when it occurs.

From the consideration of insanity in early life, and the incipient symptoms of insanity, the author passes on to the diagnosis of insanity. It is, of course, impossible for us to follow him step by step in this review. We can only mark some of the most prominent points here and there.

The author refers in the following language to the position of the "expert:" The position of a physiological "expert" is not to be ambitiously coveted. In cases of alleged insanity, he is occasionally compelled, when elucidating in courts of law, the phenomena of mental derangements, to enunciate principles, as a pioneer of truth, *in advance* of the knowledge possessed by those who sometimes examine, and often severely, unjustly, criticise and calumniate him; when giving evidence on scientific points, he is occasionally and unavoidably obliged, in the expression of his opinions, to go counter to what is termed the "generally received" notions on the subject of insanity. If it be his desire, in imitation of certain dilettanti psychologists, to sail with the popular breeze, and to pander to the opinions of the vulgar, by making his views of insanity square with those ordinarily entertained by the nonprofessional, psychologically uneducated, and medically inexperienced, part of the community, his task is a facile and an easy one; but if he forms a just estimate of his position, as a lover and cultivator of science, and possesses a philosophic appreciation of his responsible vocation as a citizen of the state, physician and medical jurist, and is resolved not to yield one inch of ground in his honest exposition of scientific truth, in deference to

popular fallacy, or in slavish obedience to ignorant abuse and noisy clamor, he must expect to pay the penalties attaching to his exhibition of moral courage, and firm and unflinching adherence to the path of public and professional duty. He may be maligned, misrepresented and traduced for adopting this honorable principle of conduct, but the cause he has espoused must eventually triumph over all difficulties, temporarily obstructing its steady, onward and advancing progress."

We would like to quote in full the author's remarks on the plea of insanity in criminal cases, but we have only room for a few. "In defending the memory of the suicide from the disgrace that would accompany a verdict of *felo de se*, the evidence of the medical man, *proving insanity*, is regarded with great respect and treated with profound deference; but in the effort to rescue a poor lunatic from the agonies of a painful death upon the scaffold, on evidence much stronger, the expert is exposed to unmitigated abuse. Instead of being considered as an angel of mercy, engaged in the exercise of a holy and righteous mission, he is viewed with suspicion, and often treated with contumely, as if he were attempting to *sacrifice*, instead of to *save* human life. The public mind is violently shocked at the commission of a horrible and brutal murder. The act is viewed in the abstract as one of great and barbarous atrocity, apart altogether from all its concomitant, extenuating, medico-psychological considerations. The cry is raised for 'vengeance!' The shout is, 'an eye for an eye! a tooth for a tooth! blood for blood!'" How true, how sadly true! It is but a few months since poor, insane Maude fell a victim to these popular errors in regard to insanity.

In another chapter the mental abilities of the insane are discussed. Their mental acuteness and instinctive sagacity is illustrated by many cases. But we have no space to extend this notice. Suffice it to say that this clear, elegantly written treatise, replete with remarkable and valuable observations by one of the first psychological physicians of the day should be found in the library of every physician, and its careful perusal by gentlemen of the bench and bar would do no harm to them, while to the general reader of cultivated taste it will be none the less interesting.

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Dr. William Langshaw, of East Cambridge, has joined the Arctic schooner *United States*, as surgeon and naturalist to the expedition.

## THE MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, SATURDAY, JULY 21, 1860.

## REFORMS IN MEDICAL EDUCATION.

With the reforms and changes in the study of medicine, indicated in our last article, it becomes necessary that the time for study should be extended. Four years cannot, at present, be considered too long a time, if we take in consideration the large amount of material which the student is obliged to master. Indeed, none of the changes spoken of in our former article can be carried out, unless the term of study is extended. The last year of study should be entirely devoted to clinical medicine and surgery, while in the three first the student will have ample time to get a thorough knowledge of the elementary parts of the science. How is it at present? Two years out of three are spent in a physician's office; and, though we would not by any means underrate the value of office-study, it must be admitted that in many important branches it fails entirely.

Let us suppose that a young man, of excellent preparatory education, to enter the office of a physician; he reads anatomy, physiology, materia medica, and surgery, perhaps, for a year. The time devoted to the first is almost a complete waste of time. Six weeks' practice in the dissecting room would teach him more than six months' reading. He wades through materia medica and therapeutics. Then a work on physiology is put in his hands, and before he has dissected, before he has any definite ideas of the structure and the tissues of the body, he is led into long and tedious disquisitions on the functions of the various organs. At the end of the first year, he attends a course of lectures. From the lecture on materia medica to anatomy, from anatomy to practice, from that to chemistry, thence to surgery, thence to physiology, thence to midwifery, he rushes in so many successive hours daily, until his head becomes dizzy and his brain whirls. Then he is expected to dissect several hours a day, write out his notes—at least study them up. Thus he spends five or

six months, roaming in that space of time through every department of medicine, getting a bird's eye view of its domains, but nothing more. He returns home, tired, worn out, and begins to realize that he has only commenced to learn *how to study*.

The interval between his attendance on the first and the second course of lectures is spent in getting order into chaos; in finding out what he knows and what he does not know. Fortunate he who succeeds in the latter, which is a much more difficult task than the former! The student has to prepare for another winter's campaign, and for the green-room. He buys a "*Compendium*," and other pontes aminorum, and memorizes day and night. Then another six lectures a day—the same, by the way, which he has heard the winter before; then an examination, a commencement, and a diploma. He is Doctor of Medicine!

Are we exaggerating when we say, that the present system of crowding a student with six lectures a day, and crowding the whole range of medical science into two courses of lectures, is inefficient for the purposes of a sound medical education?

There can be no doubt that the present term of medical study is too short, and we congratulate the profession that this fact is beginning to be acknowledged and understood on all sides. Even among the students throughout the whole country, there are many now who voluntarily attend three courses of lectures, or at least two full courses, distributed over a longer period of time. This is a sign of a better state of things to come. We hope that the time is not far distant when what is now an exception will become the rule.

*Music for the Sick.*—Florence Nightingale remarks that, "wind instruments, including the human voice, and stringed instruments, capable of *continuous sound*, have generally a beneficial effect, while the piano-forte, with such instruments as have *no continuity of sound*, have just the reverse. The finest piano-forte playing will damage the sick, while an air like home sweet home," or "*adieu à pie d'un salice*," on the most ordinary grating organ, will sensibly soothe them, and this quite independent of association.

## Correspondence.

Liverpool, July 2, 1860.

Messrs. Editors:—Having, a few days ago, paid a visit to the Liverpool Royal Infirmary, I shall, according to my promise, endeavor to give you a faithful description of it. This Infirmary is the largest of the three Liverpool hospitals, and contains about two hundred and thirty beds, being therefore about as large as our Pennsylvania Hospital. The others are recalled—one the Northern Hospital, which contains one hundred and twenty beds; the other, the Southern Hospital, which is still smaller. Besides these, there is a Fever Hospital.

The Royal Infirmary is built of stone, which, whatever may at one time have been its color, has now become very dingy; as, indeed, is universally the case with buildings in Liverpool, for the smoke, and perhaps in some measure the salt air, soon destroys the cleanly appearance of the houses. The entrance is on one side, and, on ringing a bell, you are admitted into the Dispensary. I was deceived as to the proper entrance very much in the manner in which a stranger in Philadelphia might be deceived as regards getting into our Pennsylvania Hospital. I went first to the main entrance in front of a large portico, with stone pillars, but found that it was fast locked. It was only a sham front door. The real front door was to be found at the side. In the Dispensary, where out-door patients are treated, there were about twenty or twenty-four very sickly-looking individuals waiting very patiently until it was the physician's pleasure to attend to them. In the next room to that, the wall was covered with lists of those who at different times had been officers of the establishment, and also of the contributors to the institution. There was one man who had given £1,800, another £2,000, and a large number had given smaller sums.

In my description of the institution, and of any other which I may hereafter visit, I shall adopt a standard of comparison, to which I shall constantly refer; and I think that in this manner I shall be able to give a clearer idea of what I describe. Thus, in my description of hospitals, I shall take the Pennsylvania Hospital; and, in describing colleges, I shall take our Philadelphia institutions as standards. I take it for granted, that all your readers are acquainted with these, and by indicating the point of similarity and dissimilarity merely, much trouble will be saved.

I have already intimated, that, from its looking so dirty outside, the general appearance was much inferior to that of our Pennsylvania Hospital. But that is not the only cause of inferiority. There are no trees surrounding it, (to be sure they are not as much needed in England as with us,) and the lot

itself is not more than about half the size of the beautiful lot between Spruce and Pine. The ceilings are not near as lofty as ours; the wards not as wide, and the general arrangements more awkward, as the entries are narrow and have frequent turnings.

There is, however, a bright as well as a dark side to the picture, and it would not be fair if I did not present both. Although, from the narrowness of the wards, there is not as much room between opposite beds as I had been accustomed to see, yet the distance between adjoining beds was fully as great; and although the ceilings were not at all high, yet the ventilation was perfect, as was proved by the fact, that not the slightest odor of a disagreeable nature was observable on entering the wards. There are large square openings in the ceiling by which ventilation is effected. For heating the wards, there are hot air furnaces, but not enough to give all the heat which is necessary; so that in almost every room a fireplace is requisite in addition. Each ward contains from nine to eighteen beds; the beds are very neat, but different in appearance from ours; and the uppermost cover on them, instead of being a clean white sheet, is of a sort of woolen stuff of a dark color, with the words "Liverpool Royal Infirmary" in raised letters, and occupying half the width of the bed, and perhaps even more than that. Over each bed is hung a paper in a tin case, with particulars about the patient, and very particular particulars. You can learn by these papers the disease, date of admission, time of sickness before admission, age, occupation, and place of residence of the patient; also the treatment for which considerable space is allowed, and which is always put down. The name of the attending surgeon is printed in large capitals at the head of each paper.

There is another paper hanging by the side of every bed, on which is printed a morning prayer, concluding with the Lord's Prayer, and prefaced by a notice that the services of the chaplain may be obtained by any patient who may desire it.

In the centre of the building, there is an area in which is the kitchen. Of course, the advantage is gained by this of coolness in summer, and less disagreeable smell at all times. On each side a dumb waiter runs up; on one side to the men's wards, and on the other to the women's. The large kettles, &c., in the kitchen, need no description, as similar ones can be seen in any large public institution.

The bath rooms for the patients are very large, and every thing in them is of the utmost convenience and neatness. The only other arrangement connected with the wards, which struck me as worthy of notice, was the oven for baking the patients' clothes. The object of this is, of course, to

destroy any living creatures which might, by any possibility, be existing therein.

The resident or house surgeons and physicians accompany the chief physicians in their rounds just as at home. The visit of the latter is paid at 12 o'clock, or after, instead of at 10, as with us.

Among the cases of interest which I observed, was one of a child, who had been injured by a quoit, which had been thrown into the air, and had fallen perpendicularly on its head. A remarkable feature of the case was, that the dura mater had been forced down into the brain without having been itself lacerated. No bad symptoms had taken place; but, as only four days had elapsed since the accident, there was still, of course, as Mr. Long, the surgeon, remarked, great danger. I observed a large proportion of cases of scrofulous disease, much larger than in the United States; in one of them, excision of the elbow joint had been performed, and I was shown the granulating surface in the shape of a large H. I saw two cases of men who had cut their own throats, and a case of spinal meningitis.

Fractures of the clavicle are treated in the Infirmary by merely a figure of 8 bandage; and one which I saw, and which was complicated with a broken rib, was not treated, except by position. Among the splints employed, the only new thing which I saw was more to be recommended by its simplicity than its elegance. It was to be used for stiff joints, which it was desirable to attempt to bend, and consisted of two thick wires bent at the angle of the limb, which were fastened together and padded. After having been fastened on, if the limb and the wires should be straightened out, they will remain so.

I was told that about forty students attend on the hospital in the daily visits of the physicians and surgeons. The whole forty, however, are not seen there at once. Practically, not many more than half that number is ever seen. I was shown into the operating room, which is very large and convenient for the purpose. It is not, however, at all convenient for lookers on, as there are only three benches raised, one above the other, and all of them together would certainly not accommodate more than forty.

Before I close, I should like to mention one more thing which drew my attention, and that was, that the nurses in the men's wards were all women.

There are no private rooms in the Infirmary, as it is intended exclusively as a charitable institution, and not to receive pay patients.

There is, in Liverpool, a school of medicine, which, however, is not a college, having no power to confer the degree of M. D. It may, therefore, be con-

sidered merely as an association of physicians for medical instruction.

I will now conclude my letter. I expect to go to London shortly, and there I shall probably see enough to fill more than one letter.

Yours truly,

"M. D. ABROAD."

## News and Miscellany.

**ARMY AND NAVY.**—A Medical Board, to consist of Surgeons C. A. Finley, R. S. Satterlee and C. S. Tripler, has been ordered to assemble at Baltimore, on the 20th of September next, for the examination of assistant surgeons for promotion, and of such candidates for appointment to the medical staff of the army, as may be invited to present themselves to the Board.

**Appointments**—Assistant Surgeons: Joseph H. Bill, of Pennsylvania, vice Eaton, deceased, to date from April 13, 1860.

James H. Berrien, of Georgia, vice Holden, promoted, to date from June 8, 1860.

De Witt C. Peters, of New York, June 23, 1860, to fill an original vacancy.

Charles H. Alden, of Pennsylvania, June 23, 1860, to fill an original vacancy.

Warren Webster, of Massachusetts, June 23, 1860, to fill an original vacancy.

John Vansant, of the District of Columbia, June 23, 1860, to fill an original vacancy.

Charles C. Byrne, of Maryland, vice Simpson, promoted, to date from June 23, 1860.

Archibald M. Fauntleroy, of Virginia, vice Coolidge, promoted, to date from June 23, 1860.

**Surgeons**:—Levi H. Holden, April 23, 1860, vice Wheaton, deceased.

Richard F. Simpson, June 23, 1860, to fill an original vacancy.

Richard H. Coolidge, June 23, 1860, to fill an original vacancy.

Charles C. Keeney, June 23, 1860, to fill an original vacancy.

Robert Murray, June 23, 1860, to fill an original vacancy.

Assistant Surgeon Albert J. Meyer, to be Signal Officer, with the rank of Major, June 27, 1860 to fill an original vacancy.

**Orders**:—Assistant Surgeon A. M. Fauntleroy has been ordered to report, on the 16th instant, at Carlisle Barracks, for duty as far as Fort Leavenworth, with the recruits about to



be sent to New Mexico; thence to proceed to Fort Laramie, and relieve Assistant Surgeon E. W. Johns.

Assistant Surgeon A. J. Foard has been ordered to repair—when relieved in his present duties at Camp Verde, Texas—to Baton Rouge, La., and report thence, by letter, to the Surgeon General.

Assistant Surgeon R. Bartholow has been ordered to report at Fort Columbus, on the 10th inst., for duty with the recruits under orders for New Mexico. On his arrival at the Headquarters of the Department of New Mexico, Assistant Surgeon Fauntleroy has been directed to report for orders to the Commander thereof.

Assistant Surgeon C. C. Byrne, has been ordered to repair to Camp Verde, and relieve Assistant Surgeon Foard.

Assistant Surgeon E. W. Johns, has been ordered to repair—when relieved in his present duties at Fort Laramie—to the city of New York, and report thence, by letter, to the Surgeon General, for examination for promotion.

Assistant Surgeon Glover Perin, now en route to Ringold Barracks from New Mexico, has been ordered to repair to Newport Barracks, Ky., and report thence, by letter, to the Surgeon General.

Surgeon W. J. Sloan, has been assigned to duty at Baton Rouge Barracks, and will be relieved from further service in the Department of New Mexico, on the arrival of Assistant Surgeon R. Bartholow in that Department. On his arrival at St. Louis, Mo., Surgeon Sloan has been directed to report, by letter, to the Surgeon General for special instructions.

Assistant Surgeon J. Vansant has been ordered to repair to the headquarters of the Department of Oregon, and report for duty to the commander thereof.

Assistant Surgeon W. Webster has been ordered to repair to Fort Larned, and report for duty at that station.

*The Middle Georgia Medical College*, at Griffin, Georgia, is a new institution, recently organized. The session will commence on the first Wednesday in October, and continue five months. The faculty is constituted as follows: L. L. Saunders, M. D., Professor of Anatomy; J. T. Banks, M. D., Professor of Surgery; R. B. Gardner, M. D., Professor of Materia Medica, Therapeutics and Medical Jurisprudence; F. O. Dannelly, M. D., Professor of Physiology and Pathological Anatomy; E. F. Knott, M.

D., Professor of Institutes and Practice of Medicine; S. H. Saunders, M. D., Professor of Auscultation and Percussion, and Diseases of the Skin; L. J. Robert, M. D., Professor of Medical Chemistry; T. M. Darnall, M. D., Professor of Obstetrics; M. J. Daniel, M. D., Professor of Diseases of Women and Children; J. H. Connally, M. D., Demonstrator of Anatomy; S. H. Saunders, Dean.

*Galen and the Stereoscope.*—Sir David Brewster, inquiring into the history of the stereoscope, finds that its fundamental principle was well known even to Euclid; that it was distinctly described by Galen one thousand five hundred years ago; and that Giambattista Porta had, in 1599, given such a complete drawing of the two separate pictures as seen by each eye, and of the combined picture placed between them, that we recognize in it not only the principle, but the construction of the stereoscope.—*World*.

In the Crimea, there were 28 deaths out of 33 primary amputations of the elbow joint, and of 31 secondary disarticulations, 24 were fatal. Out of 68 disarticulations of the knee, there were 62 deaths. The same operation once yielded in M. Velpeau's hands only 1 death out of 14 cases.—*M. Larry*.

*Popular Medical Jurisprudence.*—The following verdict of a coroner's jury is said to have been recently rendered:

"We find that Mr. Fink died of a natural death produced by dispepsy, owing to clams for dinner, and cholera morbus in the evening."

It had better read—*clams for dinner, and cholera morbus for supper!*

*Proportion of Multiple Births.*—Twin births, according to official statistics, vary considerably in different places. At Philadelphia, the proportion is 1 in 75; at London, 1 in 85; at Paris, 1 in 84; at Naples, 1 in 158; at Palermo, 1 in 126; at Dublin, 1 in 67; at Berlin, 1 in 88; at Leipzig, 1 in 86; at Vienna and Wurtzburg, 1 in 74; at Dresden, 1 in 68; at Heidelberg, 1 in 62; at Prague, 1 in 72; at Hamburg, 1 in 96; at Marburg, 1 in 110; at Luneburg, 1 in 118; in Prussia, 1 in 89; in Wurtemberg, 1 in 86; and in Saxony, 1 in 78. From Hoffman's report, it appears that between the years 1826-34, there occurred in Prussia 4,467,081 single births, 52,384 twin births, 659 triplet cases, and 11 quartet cases. In 1840, there occurred 574,293 single births, 6381 twin births, 72 triplets, and 1 quartet.

*Remarkable case of Polyphagy.*—If not a "graceless assumption," the following is one of the most remarkable cases of polyphagy on record:

The *Baltimore Republican* announces the death, in that city, of a man known by the sobriquet of "Eating Tom," and says that he has been known to eat a moderate sized ham, with vegetables, &c., in proportion, at one meal. Six large loaves of bread, with more than a quart of coffee or tea, would scarcely suffice for his breakfast or supper. A good sized goose or turkey would disappear from sight in a short space of time. His daughter would prepare a plum pudding at stated periods, and cook it in a bushel bag. This would serve him and two others as a dessert.

*The Death of a Centenarian.*—Barbara Nell, well known to the oldest inhabitants of Germantown, died in this city, during the past week, at the advanced age of *one hundred and ten years!* Until within a few years past, she supplied many of our families here with fruit, vegetables, &c., a business she had followed for nearly *seventy years!* Many of our people will remember her contracted form, bending under the weight of almost a century, yet cheerfully pursuing her humble avocation. At the time of her death she was perhaps the oldest inhabitant of the city of Philadelphia.

*The Turkish Bath.*—In these Turkish baths, soap and water are purely secondary agents; they are considered as barbarous, clumsy, and effete means of cleansing. The bather is first conducted into a room, which is practically a large oven, lighted from the top, and filled with moist air. This is very far, however, from being a vapor-bath; the quantity of water-vapor is small, and does not affect the transpiration of water by the skin. Of course, a profuse sweating is induced, and the skin is thoroughly softened. It is a hot bath without water, or rather with the aid of very little water. From this chamber he passes to another—the calidarium—where, freely perspiring, he is rubbed with towels or goat's hair gloves; and so great is the effect of the prior treatment, that the softened cuticle rolls off in thick flakes, and a new skin is found beneath, of which the subject of the operation little dreamed. No one who takes a Turkish bath for the first time but must be astonished at the quantity of the unnecessary cuticle which he carries about with him. Adepts tell you that "it requires

great dexterity to perform this well without rubbing some places too much, and others too little." Now comes a drenching with warm water and soap, which is not the most agreeable part of the bath, and may be considered partially unnecessary. Then the bather passes back to the tepidarium, where he is dried and clothed in warm towels; and, after a pause, thence to his frigidarium, or cool chamber, where, still clothed in warm towels, he sips coffee, smokes a narghilet, and indulges in beatific sensations which only those can know who have passed through the three purgatories of the bath. The Turkish bath is an agent of such great power in restoring the active functions of the skin, and the ordinary results of its application are so peculiarly agreeable and invigorating, that it will probably invite the attention of medical practitioners in its relations to disease. It is a powerful agent, of which the virtues are apparent; but incautiously employed by persons liable to congestion of the head or organs of the chest, it is not free from dangers, as some unfortunate circumstances have already proved.—*Lancet.*

*French Lecture Rooms.*—The French nation is so celebrated for its refinement, (none but a Frenchman knows how to eat an egg,) that we were much surprised at a description of Parisian lecture rooms, given by Dr. Chaillie in a letter to the *New Orleans Medical Journal*. They are (says the doctor) not dirty, but filthy, wretchedly small; a board six inches wide for a seat, with your vertebral column to support your back; and, if that proves tiresome, one may, by way of relief, stand up and lean against the wall.

Such is a flattering description of Prof. Velpeau's amphitheatre, where were assembled some seventy-five students, the day I heard him, and which, under no circumstances, could contain over double that number.

*Railroad Surgeons.*—On the principal railroad in Bavaria, surgeons are to be appointed, who are to receive a fixed salary, and whose business it is to attend to cases of accident in the trains, and give medical attendance to the employees of the road.

*Deaths in Philadelphia.*—From the weekly reports of the Health Officer, it appears that there were 5,414 deaths in Philadelphia from January 1st to July 1st, 1860. Of this number, 2,925 were children.

**A Simply Constructed Fire-escape**—This effective arrangement is thus described by the *Scientific American* :—

It consists simply of a rope drawn through an S-shaped tube or wound around a pivot, or otherwise so arranged that the portion of the rope on the interior of said tube, or on the outside of said pivot, causes a retardation of the downward motion of the latter, which retardation is adjusted by the strain exerted on the rope, so that persons or articles attached to said tube or to said pivot can be lowered either by the agency of the descending persons themselves or by the agency of persons on the ground, with any desired velocity. This escape is of peculiar value for hotels or other buildings in which a large number of people dwell together, and it has been successfully tried in several hotels in this city.

**Marine Sanitaria.**—The *London Lancet*, suggests the establishment of marine sanatoria, particularly for the benefit of the East Indian troops. In consideration of the great benefit which invalid soldiers experience from the return voyage to England, it is thought that they might be restored to health and continued in the service where they are needed, by giving them the advantage of the restorative influence of sea air in short sea voyages.

**Ventilation of Rooms at Night.**—An extraordinary fallacy is the dread of night air. What air can we breathe at night but night air? The choice is between pure night air from without and foul night air from within. Most people prefer the latter.

An unaccountable choice. What will they say if it is proved to be true, that fully one-half of all the disease we suffer from, is occasioned by people sleeping with their windows shut? An open window most nights in the year can never hurt any one. In great cities night air is often the best and purest air to be had in the twenty-four hours. I could better understand in towns shutting the windows during the day than during the night, for the sake of the sick. The absence of smoke, the quiet, all tend to making night the best time for airing patients. One of our highest medical authorities on consumption and climate has told me that the air of London is never so good as after ten o'clock at night.—*Florence Nightingale.*

**Dr. Hays' Arctic Expedition**—The Views of its Commander.—Dr. Hays, the Commander of the Arctic Expedition, recently gave the following outlines of his views and intentions :

He assured the committee of his perfect satisfaction with the vessel they had purchased. She had been amply strengthened, and was as secure as wood and iron could make her. She was equal, if not superior, to the "Advance," in all the qualities requisite to her peculiar service. All could be done with her that could be done with any vessel. He could not much regret that he had not steam, for the space required for coal bunks and engines would occupy in a steamer so much space that there would not be much room for provisions.

In this vessel there was sufficient food for a three years' cruise, and with economy, for a longer period. In the character and quality of the provisions supplied by the committee, he was thoroughly content. He could not ask for a more perfect outfit. Although he claimed to be a prudent man, if he had found any fault, it would have been that he had too much. All were familiar with the purposes of the expedition, which were to reach the North Pole, and to complete the exploration of the Polar Sea, which was commenced by Dr. Kane. He would push forward with all possible dispatch this summer, and, reaching Smith's Strait early in December, select a harbor as far north as 79 or 80 degrees north latitude, if possible, and there pass the winter. To effect this purpose, he would have some slight advantages in leaving earlier in the season; but during the month of August the ice was more open, and he felt very confident in being able to reach a suitable harbor this season. Next spring he would carry forward provisions, with the aid of dogs; and he would follow in person with the Francis's metallic lifeboat, in which his guests had just come on board. Should he have the happy fortune to meet open water, then he would launch this boat upon it, and push off for the Pole.

Should they not meet the open sea, they would pass another winter in the ice, and attempt to reach the North Pole by ice alone. He had, however, a firm belief they would meet an open navigable sea.

For the accomplishment of these purposes, every thing, of course, depended upon the vessel which the committee had just presented

him. Yet, with such a craft, he felt confident and hopeful. Referring to the inception of the expedition, he said it was true that the first proposal was made by him to the Geographical Society of New York. The contributions of that city and Philadelphia had been liberal and satisfactory; but, owing to the accident of finding a vessel so admirably suited for the service, and the lateness of the season, which precluded the possibility of sending the vessel to New York, the exhibition was now about to sail from Boston. The liberality displayed by the Boston committee, and the citizens of Boston, was unbounded. In his officers and men he had perfect reliance. They were all devoted to the cause. The astronomer of the expedition, Mr. Sontag, whom he had appointed second in command, had been his companion through previous dangers and privations, and having tried him, he knew him to be earnest, brave, and intelligent. The scientific world might well entrust the important interest of the expedition to his intelligent zeal.

His executive officer, or master, Captain McCormick, had been known to him for several months, and he had implicit faith in his devotion to the cause, and his determined energy of character. He was a worthy sailor and a brave man. His second officer was no less devoted, and, although he had known him only for a short period, he was satisfied that he possessed those qualities of coolness, caution, and daring, needed for stern emergencies. He had about him a corps of young, well educated, and intelligent men, who would not only render valuable assistance in the scientific labors of the expedition, but who, with a zealous love of enterprise and adventure, would soon adapt themselves to the narrow quarters, and their calling. The men who went before the mast upon small pay, with no other compensation but their outfit, bore about them those marks of manly courage and endurance, which were calculated to inspire a commander with high hopes of gallant followers. Viewed altogether, he believed that if success did not crown his endeavors, it would not be for the want of any of the means to accomplish his end.

Many misgivings had existed in the minds of persons appealed to by the committee, on the ground of the hazardous nature of the undertaking, and fears had been expressed that an expedition would have to be sent after him. He would briefly say, that he desired no such effort to be made, even should they not return after an absence of two winters, for they had abundant stores, and that he believed that

wherever they might be, if alive, they could find their way home, even should their vessel be lost in the ice. Whatever fortune might happen to them, he will keep his crew at the vessel, either until the objects of the expedition were accomplished, or until a further stay in the region becomes unsafe. Then, and not until then, would he return home.

*The Medical Profession* is represented, in the parliament of the new kingdom of Italy, by a dozen physicians, who have been chosen members; among these is Farini, Ex-Governor of l'Emilie. Two of the chief representatives of Italian medicine have been appointed senators.—*Gaz. Hebdom.*

*Toads living Enclosed for Years in Plaster of Paris.*—Toads are said to have been found alive after being for a long term of years shut up in stone. M. Séguin, of Paris, wishing to ascertain what amount of truth there might be in stories of this kind, enclosed some toads in plaster, and left them in the middle of these blocks of artificial stone. At various intervals, he has broken some of these blocks, and has found a certain number of the toads alive. One of them had been deprived of air for ten years, another twelve, and a third fifteen years. Two still remain enclosed; and, as M. Séguin is very old, and fears that these two blocks may be lost to the purposes of science, he offers them to the Academy of Sciences, in order that they may hereafter further test the phenomenon, which have been accepted, intending, after a verification of the dates of sequestration, to have the plaster broken in the presence of a commission.

*To Subscribers.*—We cannot hold ourselves responsible to supply missing numbers of the *REPORTER*, unless subscribers notify us within two or three weeks after the date of the missing number.

#### Answers to Correspondents.

COMMUNICATIONS RECEIVED.—England, "M. D. abroad"—*Isis*, Dr. W. T. Ellegood—*N. Jersey*, Dr. C. Marrug, [with encl.] Dr. G. J. Janeway, [with encl.] Theod. S. Price, [A. D. & Grant, Dr. J. Theod. Calhoun—*New York*, Dr. H. K. Horton, [with encl.] Thos. J. Winchester—*Ohio*, Drs. G. F. and M. H. H. [with encl.] Dr. E. B. Ripley—*Pennsylvania*, Dr. S. R. H. [with encl.] Dr. W. W. Wall, [with encl.] Dr. Dan. H. [with encl.] Dr. J. B. Wadsworth, [with encl.] Dr. R. H. Smith, Dr. A. G. Walter—*South Carolina*, Dr. E. M. Dubose—*Tennessee*, Dr. C. Martin.

Office Payments.—By Mr. Swalm: Drs. Rich, Howland, Baber, Scheringhausen, Mr. B. C. Everett, (adv.) Dr. W. T. Taylor, Dr. G. Truman, Dr. Rheinstein.